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ABSTRACT

This report presents two discussions of conceptual and infrastructure issues that state mental health systems serving children with emotional disturbances must consider to make an effective transition towards a managed care organization of services under Medicaid. The first discussion, "Clinical Experiences in Managed Care Implementation for Children with Serious Emotional Disturbances" by Theodore Fallon, describes a set of demonstration programs that are constructing arrays of services to address the needs of the most disturbed children and youth and their families. Five attributes contributing to program success are identified, such as multiple coordinated services which affect all aspects of the family's life. The second discussion, "Best Principles for Managed Care Request for Proposals" by Andres J. Pumariega, describes a document designed to assist state decision makers in selecting managed care Medicaid vendors or developing public managed care systems. Principles address such issues as governance of service systems, design of benefits, access to services, development of treatment plans, triage and assessment, treatment services, case management, quality assurance, information management, and provider support by states. (DB)

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Managed Care Approaches to Children's Services within Public Systems of Care

Authors

Introduction
Clinical Experiences in Managed Care Implementation for Children with Serious Emotional Disturbances
Best Principles for Managed Care Request for Proposals

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Introduction

Over the past three to five years, there has been a rapid transition to managed care models of health care financing and organization in the United States. This transition is now reaching the area of public mental health services. As states and governmental entities seek to control the increasing costs of Medicaid programs, many are moving towards implementation of managed care principles in the funding and delivery of mental health services. States are pursuing different models of managed mental health services under both the 1150 and 1915 Medicaid waivers, some contracting with established managed care providers and others attempting to convert components of their public systems into managed networks.

This transition, however, is not based on any solid data concerning the funding needed to serve populations traditionally served by the public mental health system, nor has it been based on any of the solid conceptual models and principles which have been tested with these populations. The managed care models which have been typically implemented by managed care contractors have not taken into account the special needs of Medicaid-covered populations. These special needs include children with severe emotional disturbances and other disabilities, economically distressed families, and members of under-served minority groups, as opposed to the majority middle class populations around which managed care services were initially developed.

This oversight has already led to adverse consequences in some state managed Medicaid contracts where the needs for services in these populations (and the consequent capitation) was grossly underestimated. On the other hand, many state mental health agencies are attempting to convert into

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managed care organizations and funding of services, but often without the infrastructure support for a successful conversion.

These summaries will address conceptual and infrastructure issues which both traditional managed care providers and converting state mental health systems must face to make an effective transition towards a managed care organization of services.

Clinical Experiences in Managed Care Implementation for Children with Serious Emotional Disturbances

Theodore Fallon, M.D., M.P.H.

The Robert Wood Johnson Foundation funded eight demonstration sites around the country with the goal of constructing arrays of service that might address the range of needs for the most disturbed children and youth and their families. The actual structures of these programs varied considerably and were each suited for the political, social, and clinical climate in which they were implemented. This project, the Mental Health Service Program for Youth, yielded eight examples of what is possible given adequate resources.

Clinical aspects of these programs were examined by observing the clinical work through case conferences by visiting clinicians. The success of these programs in working with these disturbed youth and their families seemed to be dependent on a number of attributes:

1. The services provided impact on all aspects of the youth and his family's life. At a clinical level, this translates into multiple system involvement including juvenile justice, child welfare, education, and mental health. On a systems level, this translates into pooled funding of these agencies, in essence, pooling an array of resources and flexibly determining their most efficacious use. An example of this was seen at one site when a physically large adolescent repeatedly threatened the residential staff. During these times, the juvenile justice system allowed use of the detention center for time out periods. The youth was able to settle down enough to use residential support and educational services, and eventually the youth became a good student.
2. This example also illustrates the utility of coordinated services.
3. Services also need to be attractive. Many examples were seen in which youths and families had repeatedly rejected services, but when the services offered something desirable, families used them and in that setting were able to develop alliances with workers.
4. The services that were the most successful involved

4. The services that were the most successful involved considerable creativity in the service of being responsive to the youth and family. This means that the clinicians had control of the services and access to experts if they themselves were not expert. This expertise involved two components: (a) knowledge and practical skills in engaging and holding on to the families and children (characterized by focusing on the child and families' strengths, building rapport and self esteem); and (b) knowledge and practical skills in assessing and working with deficits including psychopathology (necessary in order to know how to direct the rehabilitative services that were needed to move the child and family toward normal development).
5. The services needed to have sufficient resources to be able to sustain them for as long as was necessary. This required a commitment on the part of the organizations involved (i.e., an ability to withstand the political changes as well as the personnel changes). This attribute seemed to be the most difficult to attain, especially in the environment of managed competition where competition implies competition of services where one naturally displaces another.

These five attributes were present to some degree in all of the systems of care that were able to make gains in working with children and youth with serious emotional disturbances.

Best Principles for Managed Care Request for Proposals

Andres J Pumariega, M.D.

Children and adolescents covered by Medicaid often have multiple developmental needs and complex problems. Effective intervention thus needs to include a full array of services in a community-based system of care, based on Child and Adolescent Service System Program (CASSP) principles. The American Academy of Child and Adolescent Psychiatry's Task Force on Community Systems of Care, in collaboration with other mental health professional and service associations and organizations, has developed a document titled Best Principles for Managed Medicaid Request for Proposals.

The Best Principles for Managed Medicaid Request for Proposals is designed to assist state decision makers in selecting managed care Medicaid vendors or developing public managed systems that can most effectively serve the population of Medicaid covered child population, particularly multi-problem children with severe emotional disturbances. It defines principles that should be inherent in high quality programs. It addresses such issues as governance of service systems, design of benefits, access to

services, development of treatment plans, triage and assessment, treatment services, case management, quality assurance, information management, and provider support by states.

Providing a full continuum of services allows the care providers to customize the care plan to most effectively help the patient and family. The focus of such a model is on managing services rather than managing benefits a priori, which is discriminatory and restrictive with under-served populations. This model also ensures coordinated care and the establishment of communication and collaboration across disciplines and agencies for effective coordination of services. Care plans must be patient and family centered, with their full involvement in the assessment and treatment processes. These programs also need to develop programs and monitor outcomes in the following areas: (a) access, (b) functional and clinical outcomes, (c) prevention, (d) wellness, (e) community acceptance/responsiveness, and (f) patient/family satisfaction.

This document has been forwarded to all 50 Medicaid directors, and has received overwhelming positive responses, including responses from over 40 states requesting more information and consultation. Information regarding the principles covered in this document, as well as the approaches being considered to evaluate its adoption and implementation can be obtained from the author.

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